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Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth ☐ Female ☐ Male ☐ "X" or Intersex

Current gender ☐ Female ☐ Male ☐ Transgender male ☐ Transgender female ☐ Other

Place of residence ☐ Home ☐ Nursing facility ☐ Other

Race/ethnicity Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan Contact Information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan
☐ **MassHealth Drug Utilization Review Program** Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)
☐ **Fallon Health** Online Prior Authorization: go.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
☐ **Health New England** Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **Mass General Brigham Health Plan** Online Prior Authorization: provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (866) 255-7569 - Tel: (877) 433-7643
☐ **Tufts Health Plan** Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
☐ **WellSense Health Plan** Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Pediatric Behavioral Health Medication Initiative
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

The **Pediatric Behavioral Health Medication Initiative** requires prior authorization for pediatric members (generally members < 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e. polypharmacy) that have limited evidence for safety and efficacy in the pediatric population. For a comprehensive medication list and additional information about the **Pediatric Behavioral Health Medication Initiative**, including PA requirements and preferred products please refer to the MassHealth Drug List at **www.mass.gov/druglist.**

Medication information

Section I. Please complete for all requests for medications subject to the Pediatric Behavioral Health Medication Initiative for members < 18 years of age.

Is the member currently in an acute care setting?

☐ Yes. (Inpatient) ☐ Yes. (Community Based Acute Treatment) ☐ Yes. (Partial Hospitalization) ☐ No

For members who are in an acute care setting, please document the outpatient prescriber after discharge.

Prescriber name _____ Contact information _____

Has the member been hospitalized for a psychiatric condition within the past three months?

☐ Yes. Please document dates of hospitalization within the past three months. _____ ☐ No

On the current regimen, is the member considered to be a severe risk of harm to self or others?

☐ Yes. Please provide details. _____ ☐ No

For regimens including an antipsychotic, are appropriate safety screenings and monitoring being conducted (e.g. weight, metabolic, movement disorder, cardiovascular, and prolactin-related effects)?

☐ Yes ☐ No. Please explain. _____

Has informed consent from a parent or legal guardian been obtained?* ☐ Yes ☐ No

Please indicate prescriber specialty below.

☐ Psychiatry ☐ Neurology ☐ Other _____

☐ Specialist consult details (if the prescriber submitting the request is not a specialist)

_____

Name(s) of the specialist(s) _____ Date(s) of last visit or consult _____

Contact information _____

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician, if applicable. _____

Please document member custody status.

☐ Parent/Guardian ☐ Department of Children and Families (DCF)

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Please document member placement status.

☐ Home with Parent/Guardian ☐ Foster Care ☐ Residential Treatment Facility

☐ Uncertain ☐ Other

Please document agency involvement.

☐ DCF ☐ Department of Mental Health (DMH)

☐ Department of Developmental Services (DDS) ☐ Department of Youth Services (DYS)

Is the member/family currently receiving appropriate psychotherapeutic and/or community based services for the targeted clinical mental health related concerns (e.g., Applied Behavioral Analysis, Children's Behavioral Health Initiative, school interventions, specialized placement)?

☐ Yes. Please document details of interventions below, if applicable. ☐ No

Psychiatric care provided is coordinated with other psychotherapeutic and community based services. ☐ Yes ☐ No

Is this member a referral candidate for care coordination? ☐ Yes ☐ No

If yes, MassHealth will offer this member care coordination services. Please describe which additional behavioral health services would be beneficial.

** Sample informed consent form available on the MassHealth PBHMI Information webpage. For additional information go to: https://www.mass.gov/info-details/pediatric-behavioral-health-medication-initiative-pbhmi-information*

Section II. Polypharmacy within the same medication class [e.g., antidepressants, benzodiazepines, cerebral stimulants, mood stabilizers (agents considered to be used only for seizure diagnoses are not included)]. Complete this section for all members < 18 years of age if request will result in polypharmacy within the same medication class.

Please document complete treatment plan (include all agents requested from the same medication class and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1. Medication name/dose/frequency Indication
2. Medication name/dose/frequency Indication
3. Medication name/dose/frequency Indication
4. Medication name/dose/frequency Indication
5. Other(s)

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more agents within the same medication class for this member.**

Please document clinical rationale for polypharmacy within the same medication class for this member.

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Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen.

***Attach a letter with additional information regarding medication trials as applicable.*

Section III. Antipsychotic Polypharmacy. Complete this section for all members < 18 years of age if request will result in prescription of two or more antipsychotics for ≥ 60 days within a 90-day period.

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation] and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1. Antipsychotic name/dose/frequency Indication
2. Antipsychotic name/dose/frequency Indication
3. Antipsychotic name/dose/frequency Indication
4. Other(s)

Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.

☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

☐ Member experienced an inadequate response or adverse reaction to two monotherapy trials with antipsychotics.

Drug name 1 Dates/Duration of use

Drug name 2 Dates/Duration of use

☐ Member is transitioning from one antipsychotic to the other.

☐ Other, please explain.

☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
   ☐ Yes ☐ No
2. Has the member been on the requested regimen for ≥ 12 months?
   ☐ Yes. Please document clinical rationale for extended therapy.
   ☐ Previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation.
   ☐ Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.
   ☐ Other significant barrier for antipsychotic therapy discontinuation. Please explain.
   ☐ No

☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

☐ Member is transitioning from one antipsychotic to the other.

☐ Member is tapering antipsychotic. Please describe taper plan including duration.

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Section IV. Behavioral Health Medication [e.g., antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, modafinil, mood stabilizer (agents considered to be used only for seizure diagnoses are not included), naltrexone, or viloxazine] for members < six years of age.

Please document complete treatment plan (medication name/dose/frequency/duration and indication or ICD-10 code, if applicable) for the requested behavioral health medication(s).

Please document any previous medication trial(s). Include drug name, dates/duration of use, and outcome.**

Please document clinical rationale for use of an antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, modafinil, mood stabilizer, naltrexone, or viloxazine for this member < six years of age.

***Attach a letter with additional information regarding medication trials as applicable.*

Section V. Antipsychotic Request for Members < six years of age.

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation] with dose/frequency/duration and indication(s) or ICD-10 code(s), if applicable), for the requested medication(s)).

Please select the stage of treatment and clinical rationale for use of an antipsychotic for this member < six years of age.

- ☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)
- ☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)
  1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
     ☐ Yes ☐ No
  2. Has the member been on the requested regimen for ≥ 12 months?
     - ☐ Yes. Please document clinical rationale for extended therapy.
       - ☐ Previous efforts to reduce/simplify the antipsychotic regimen in the past 12 months resulted in symptom exacerbation.
       - ☐ Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.
       - ☐ Other significant barrier for antipsychotic therapy discontinuation. Please explain.
     - ☐ No
- ☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)
  - ☐ Member is transitioning from one antipsychotic to the other.
  - ☐ Member is tapering antipsychotic. Please describe taper plan including duration.

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Section VI. Alpha$_2$ Agonist or Cerebral Stimulant Request for Members < three years of age.

Please document complete treatment plan (medication name/dose/frequency/duration and indication or ICD-10 code, if applicable) for the requested alpha$_2$ agonist and/or cerebral stimulant medication(s).

Please document any previous medication trial(s). Include drug name, dates/duration of use, and outcome.**

Please document clinical rationale for use of an alpha2 agonist and/or cerebral stimulant for this member < three years of age.

***Attach a letter with additional information regarding medication trials as applicable.*

Section VII. Hypnotic Request for Members < six years of age.

Please document complete treatment plan (medication name/dose/frequency/duration and indication or ICD-10 code, if applicable) for the requested hypnotic medication(s).

Please document if member has other behavioral health comorbidities (e.g., anxiety, depression, ADHD).

Please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.**

Please document clinical rationale for the use of a hypnotic agent for this member < six years of age.

***Attach a letter with additional information regarding medication trials as applicable.*

Section VIII. Multiple Behavioral Health Medications. Complete this section for all members < 18 years of age if request will result in prescriptions of four or more behavioral health medications within a 45-day period. For a complete list of all behavioral health medications, please refer to the MassHealth Pediatric Behavioral Health Medication Initiative.

Please document complete treatment plan (include all behavioral health agents and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1. Medication name/dose/frequency Indication

2. Medication name/dose/frequency Indication

3. Medication name/dose/frequency Indication

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4. Medication name/dose/frequency Indication

5. Medication name/dose/frequency Indication

6. Medication name/dose/frequency Indication

7. Other(s)

Please document monotherapy trials (include drug name, dates/duration of use, and outcome) tried before prescribing a polypharmacy regimen for this member.**

Please document clinical rationale for use of multiple behavioral health medications for this member < 18 years of age.

Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen.

***Attach a letter with additional information regarding medication trials as applicable.*

Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Section X. Please complete and provide documentation for exceptions to Step Therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No
   If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen? ☐ Yes ☐ No
   If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

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3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

   If yes, please provide details for the previous trial.

   Drug name _____ Dates/duration of use _____

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

   Briefly describe details of adverse reaction or inadequate response.

   _____

   _____

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member?

   ☐ Yes. Please provide details. _____

   ☐ No

Please continue to next page and complete Prescriber and Provider Information section.

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Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

E-mail address

Telephone No.* Fax No.*

* *Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider Date